West Nile Virus Investigation Form

Utah Department of Health

Patient Information

Name_____
LAST FIRST MIDDLE

Address_____
Street address City State Zip

Phone number (_____)_____

Date of Birth ____/_____/_____ Gender: M F
mm dd yy

Race: White Black Asian/Pacific Islander Native American

Ethnicity: Hispanic Non-Hispanic
Contact name (if patient is unable to answer questions)_____

Clinical Information – PHYSICIAN TO FILL OUT (check yes for all that apply)

SYMPTOM ONSET DATE:_____

☐ *WEST NILE FEVER*: Febrile illness with sudden onset accompanied by malaise, vomiting, myalgia, anorexia, eye pain, rash, nausea, headache, lymphadenopathy.

☐ *NEUROINVASIVE*:

- ☐ *Meningitis:* Sudden onset of febrile illness with signs and symptoms of meningeal involvement, possible rash, transient paresis and encephalitic manifestations may occur. Paralysis is unusual.
- ☐ *Encephalitis:* Febrile headache, acute onset, fever, disorientation.
- ☐ *Acute Flaccid Paralysis:* Acute onset of asymmetric weakness and areflexia but no sensory abnormalities. Possible involvement of spinal anterior horn cells, resulting in a poliomyelitis-like syndrome.

Laboratory

Either attach the laboratory report or completely fill out the following chart:

Name of laboratory performing tests: _____

Specimen source:	**SERUM**	**CSF**	
IgM serology (EIA/ELISA)	Reactive	Non-reactive	Test date
Numerical Value:	_____	_____	_____
IgM serology (EIA/ELISA)	Reactive	Non-reactive	Test date
Numerical Value:	_____	_____	_____

Specimen source:	**SERUM**	**CSF**	
*Total IgG serology (EIA/ELISA)	Reactive	Non-reactive	Test date
Numerical Value:	_____	_____	_____
*Total IgG serology (EIA/ELISA)	Reactive	Non-reactive	Test date
Numerical Value:	_____	_____	_____

**IgM positivity is suggestive of acute infection. IgG positivity alone does not suffice for determining diagnosis. IgG results can cross-react with the other flaviviruses listed above.*

CSF Results:

Date:_____ Culture:_____

Protein:_____ Glucose:_____

WBC:_____ RBC:_____

Past or Present Medical History (these can affect interpretation of lab results)

Past vaccination or past exposure/infection of any of the following (circle all that apply):

St. Louis encephalitis

Japanese encephalitis

Dengue virus

Yellow Fever

Powassan virus

Tick-borne encephalitis complex viruses

Murray Valley encephalitis

Hospitalized? YES NO

Date admitted: _____ Date discharged: _____

Hospital: _____

Did patient die? YES NO

If yes, date expired:_____

Other modes of transmission (Check if applicable)

☐ Transfusion in 20 days prior to onset of symptoms?
Institution's name:_____
Date of transfusion:_____

☐ Transplant within 4 weeks prior to onset of symptoms?
Institution's name:_____
Date of transplant:_____

☐ Patient pregnant? Due date:_____

☐ Patient breastfeeding or being breastfed?
Duration:_____

☐ Patient have workplace exposure (needle stick, laceration, etc.)

☐ Donate blood/organs?
Institution's name:_____
Date of donation:_____

Travel:

Has patient traveled in the 4 weeks prior to onset of symptoms? Yes No

If yes, where?_____

Patient's physician and phone number:

Reporting Date:

Please Fax to Local Health Department Number

Mosquito Abatement Information:

Home address:_____
Standing water at this location? Yes No
Mosquitoes Observed? Yes No
If yes, time observed:_____

Work address:_____
Standing water at this location? Yes No
Mosquitoes Observed? Yes No
If yes, time observed:_____

Recreational Places:_____
_____
_____
Standing water at these locations? Yes No
Mosquitoes Observed? Yes No
If yes, time observed:_____

Please fax this form to your local Mosquito Abatement District

May 23, 2005